SAMHSA-HRSA
Center for Integrated Health Solutions

Privacy Concerns, Health Information Exchange and Care Coordination

Region IX and X

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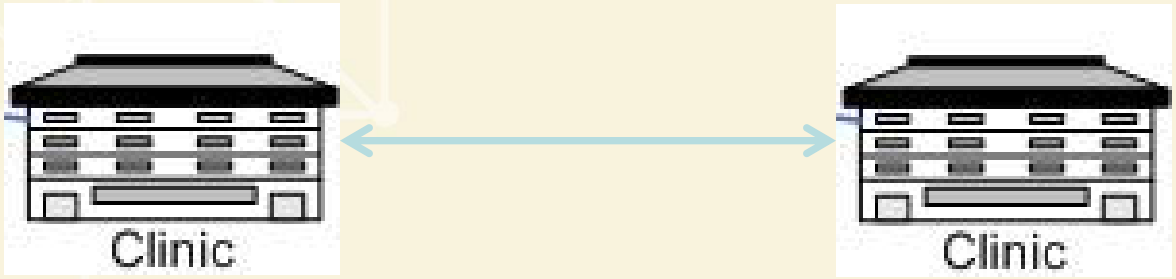
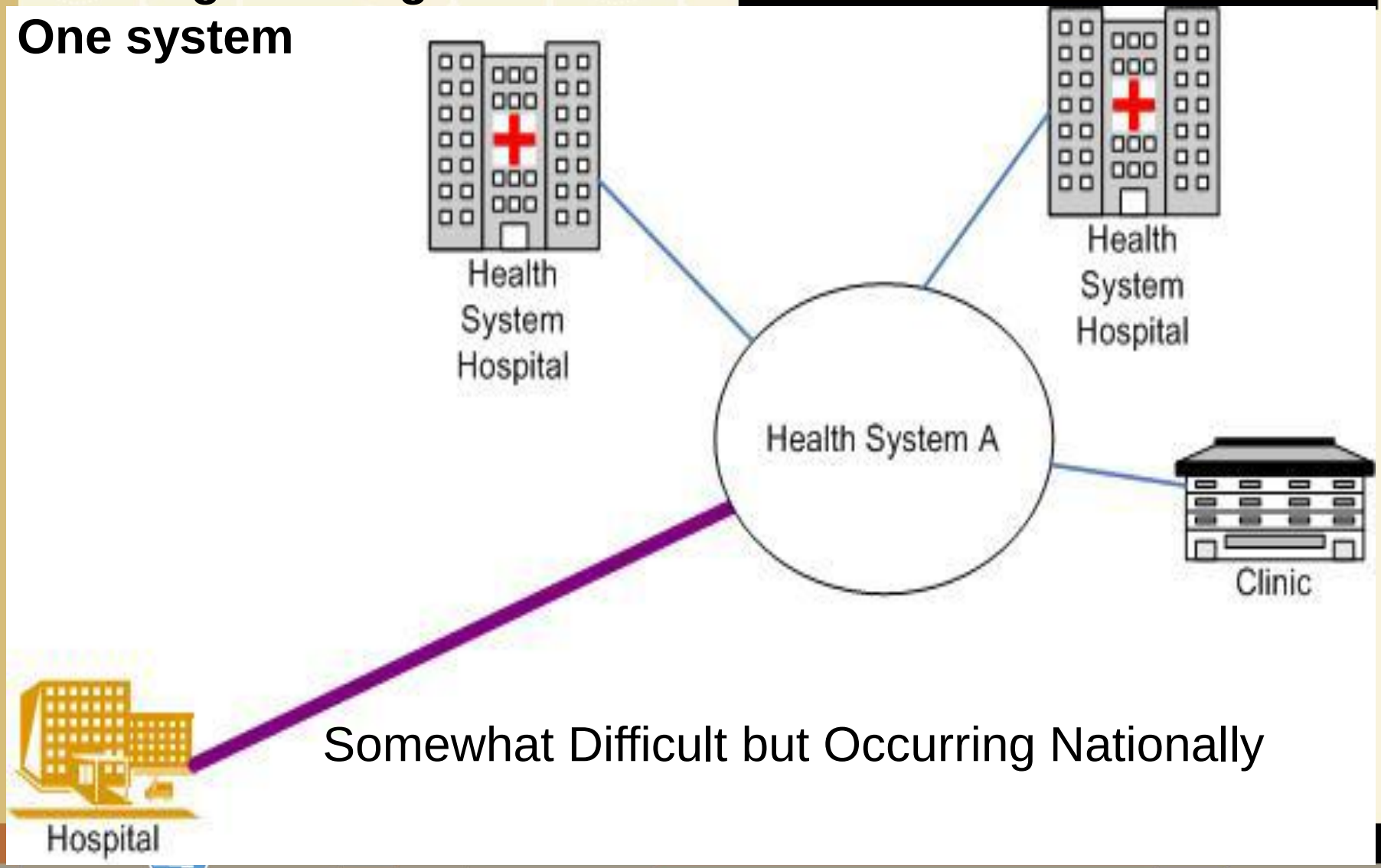
Flavors of Exchange

Secure Messaging Exchange
Uses DIRECT Protocols
Meets Meaningful Use Requirements



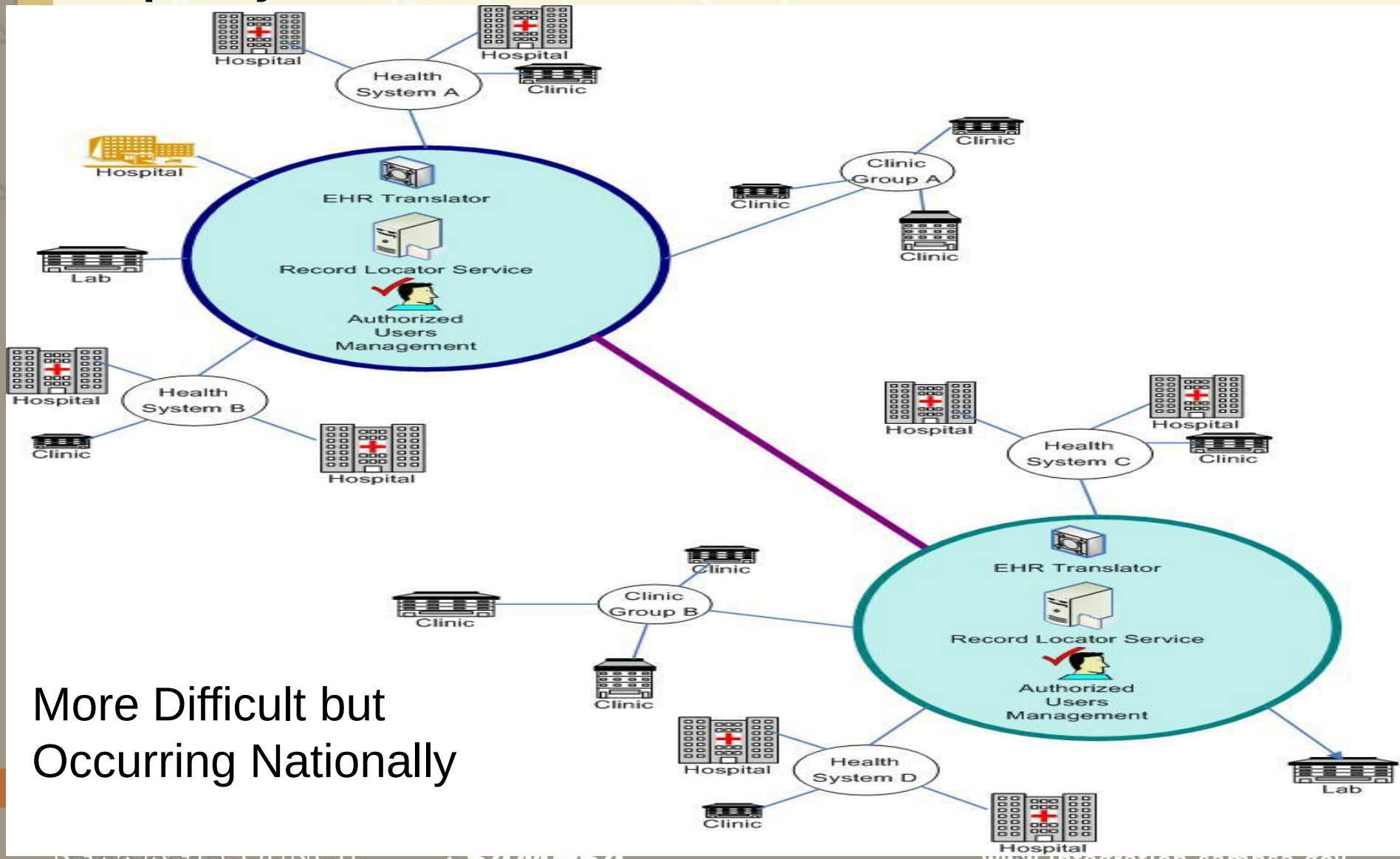
Easy

Exchange Among Providers in One system



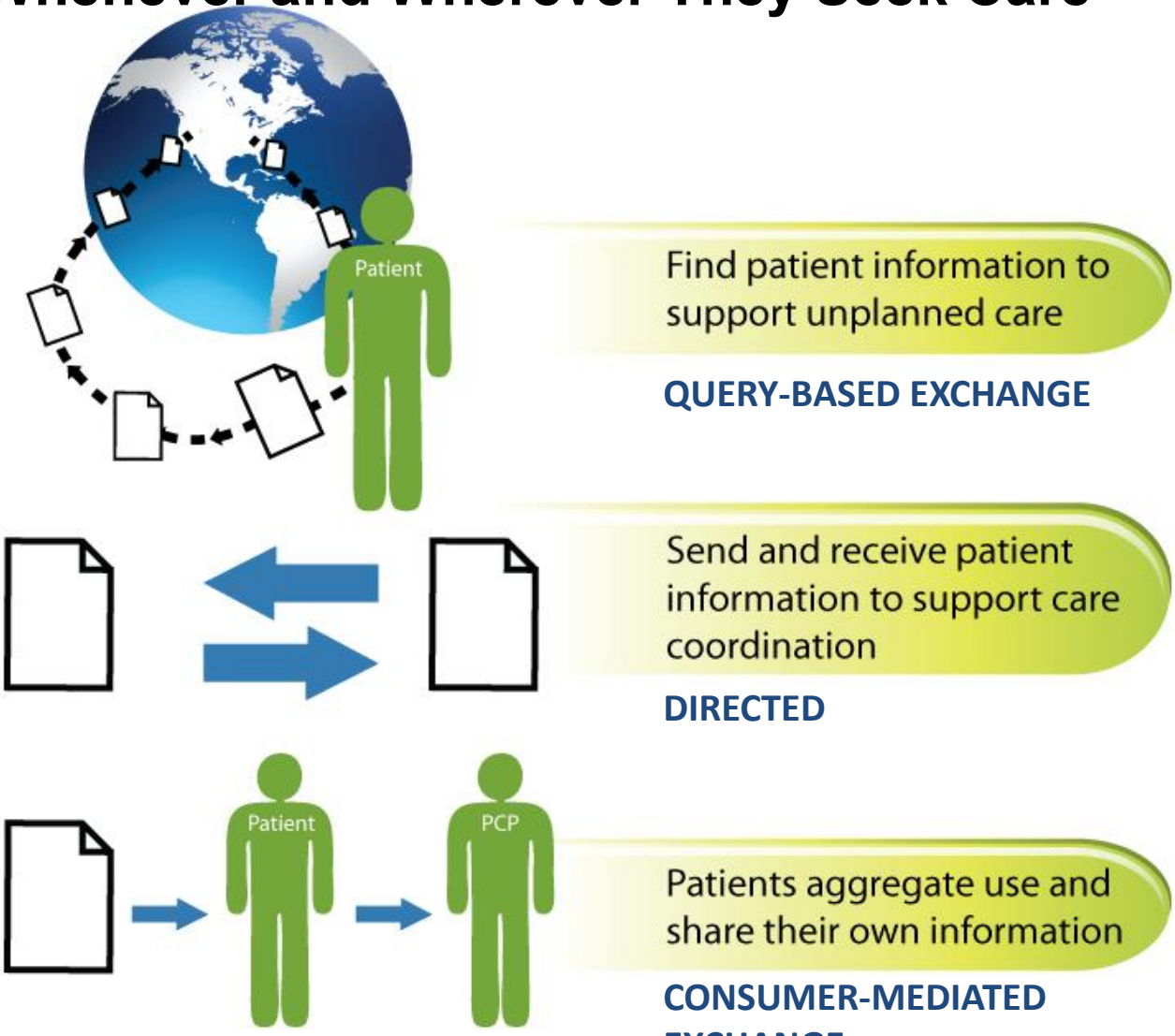
Somewhat Difficult but Occurring Nationally

Exchange Among Providers in Multiple Systems



More Difficult but Occurring Nationally

ONC's Goal - Information Securely Follows Patients Whenever and Wherever They Seek Care

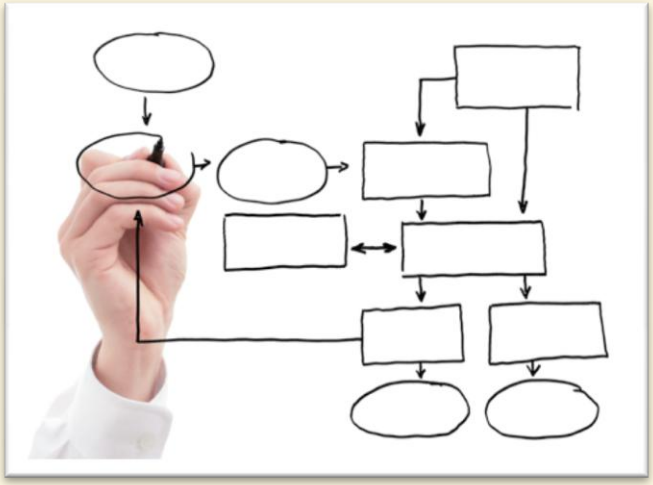


MULTIPLE MODELS

ONC's Approach

Interoperability is a *journey*, not a destination

Leverage *government as a platform* for innovation to create conditions of interoperability



Health information exchange is *not one-size-fits-all*

Multiple approaches will exist *side-by-side*

Build in *incremental steps* – "don't let the perfect be the enemy of the good"

ONC's Role - Reduce Cost and Increase Trust and Value To Mobilize Exchange

COST

Standards: identify and urge adoption of scalable, highly adoptable standards that solve core interoperability issues for full portfolio of exchange options
Market: Encourage business practices and policies that allow information to follow patients to support patient care
HIE Program: Jump start needed services and policies

VALUE

- Payment reforms
- Meaningful Use
- Interoperability and wide-scale adoption

TRUST

- Identify and urge adoption of policies needed for trusted information exchange

ONC's ROLE

Exchange Priorities in 2012 - Driving Forward on Multiple Fronts

- More rigorous exchange requirements in Stage 2 to support better care coordination
- Standards building blocks are in place, with clear priorities to address missing pieces in 2012
- NwHIN Governance increases trust and reduces the need for one-to-one negotiations among exchange organizations
- State HIE Program jump starts needed services and policies

More Rigorous Exchange Requirements in Stage Two to Support Better Care Coordination

Proposed Stage Two Meaningful Use Exchange Requirements (summary)

- Provide summary of care document for more than 65% of transitions of care and referrals with **10% sent electronically** (across vendor and provider boundaries)
- Patients can **view, download or transmit** their own health information
- **Successful ongoing submission** of information to public health agencies (immunizations, syndromic surveillance, ELR)

Standards Building Blocks are in Place, with Clear Priorities to Address Missing Pieces in 2012

ONC Made Big Strides to Enable Exchange in Stage 1

The first challenge was to make sure that information produced by every EHR was understandable by another clinician and could be incorporated into his EHR

With the vocabularies, code sets and content structure standards in Stage 1 meaningful use every certified EHR can produce the standardized content needed:

- Produce and consume a standardized care summary
- Maintain standardized medication lists
- Consistently report quality measures and public health results
- Consume structured lab results

Additional Critical Pieces Are Now In Place

Next we needed a common approach to *transport*, allowing information to move from one point to another

- We now have two easily adopted standards for *transporting* information – NwHIN Direct and the transport protocol used in NwHIN Exchange

And it was clear that we needed more highly specified standards to support care transitions and lab results delivery

- For the first time in our country's history there is a single, broadly-supported electronic data standard for patient care transitions

This Year We Will Address the Missing Components to Support Scalable Exchange

- **Directories** – standards and policies to make them consistent, reliable, findable and open to be queried
- **Certificate management and discovery** - common guidelines for establishing and managing digital certificates and making the public keys "findable"
- **Governance** - baseline set of standards and policies that will accelerate exchange by assuring trust and reducing the cost and burden of negotiations among exchange participants

What will be Exchanged

C32, CCR/CCD, CDA

Clinical Element Data Dictionary

http://wiki.siframework.org/Transitions+of+Care+Initiative+CEDD

- Acknowledgement Information
- Admitting and Discharge Diagnoses
- Allergies and Intolerances
- Audit Event Information
- Behavioral Health
- Care Team Members
- Clinical Research Information
- Consistent Time
- Consult(s) Assessment(s) and Plan(s) Recommendations
- Culturally Sensitive Care

Behavioral Health Specific Data Elements

- Confidentiality Code
- DSM Axis 1
- DSM Axis 2
- DSM Axis 3
- DSM Axis 4
- DSM Axis 5
- Environmental Factors
- GAF Score
- Homicidal Ideation
- Suicidal Ideation
- Treatment Referral

What other elements do behavioral health providers need to do our job??

- Demographics
- Diagnosis
- Diet and Nutrition
- Encounter
- Electronic Service Information
- Existence of Advance Directives
- Facility
- Family History
- General Results
- Goals

- Health Record
- History of Present Illness
- Immunization History
- Individual Provider Identity
- Invasive and Non-Invasive Procedures
- Medical Equipment
- Medical History
- Medication
- Medications List
- Operative Summary

- Order
- Organizational Provider Identity
- Patient Consent Directive
- Patient Contact Information
- Patient Information
- Patient Instructions
- Payer Information
- Physical Activity
- Physical Exam
- Policy

- Primary Care and Designated Providers
- Problems List
- Procedure
- Provider Address
- Provider Certification
- Provider Directory Content Profile
- Provider Directory Identification
- Provider Directory Individual Name
- Provider Directory Security Profile
- Provider Professional Degree

- Provider Telephone
- Reason for Consult Request
- Report
- Result
- Review of Systems
- Social History
- Specimen
- State License
- Support Contacts
- Surgery

- Surgical/Procedural History
- System Identity
- User Access Information
- Vital Signs
- Women's Health

- Note: Psychotherapy Notes are Not Exchanged

Overview of HIE Activity Informing Consent Management Issues

Under the Center for Integrated Health Solutions (CIHS)

5 States Selected

- IL
- KY
- ME
- OK
- RI

HIE Supplement

- Coordination with other Federal Programs & Initiatives
- Coordinating Activities with
  - HL7 Behavioral Health CCD Workgroup
  - ONC's Standards and Interoperability Framework Transitions of Care Workgroup
  - ONC's Standards and Interoperability Framework Data Segmentation Workgroup
  - ONCs State Health Policy Consortium Project (RTI Initiative) for behavioral health data sharing
    - AL, FL, KY, NE, NM, MI Plus other states
- Other states are also participating: CO; NY; UT

Biggest Hurdle

42 CFR Part 2 Consent Management
"To Whom"

This is being worked on now!!

- Awareness of What is Possible Today
- Planning for What Will be Possible in the Future
- Recognize we are in a Transition Period
  - Not all 42 CFR conditions can be fully met

Predominant Challenge:

- **Development of a 42 CFR Compliant Consent that is Computable in a HIE Environment**

Our Approach:

- Build on What is Already Developed
- Coordinate with ONC & S&I Workgroups
- Coordinate with SAMHSA
- Ensure Legal Input
  - 3 of 5 HIEs have their legal experts regularly involved on the calls
- Identify current “Better Practices”

- 42 CFR Regs and SAMHSA FAQs 1 and 2 side by side as Consent developed
- HIEs obtained input from their Behavioral Health Workgroups
- HIEs invited their vendors to participate and comment as well
- Everything in "Black" was reviewed and found acceptable by everyone
- "Red" indicates problem areas not yet resolved

(as of 6/29/12 still in process of determining a resolution)

42 CFR Requirements for Consent (SAMHSA FAQs 2010)

A written consent to a disclosure under the Part 2 regulations must be in writing and include all of the following items (42 CFR § 2.31):

1) the specific name or general designation of the program or person permitted to make the disclosure;

2) the name or title of the individual or the name of the organization to which disclosure is to be made;
3) the name of the patient;
4) the purpose of the disclosure;
5) how much and what kind of information to be disclosed;

6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient;
7) the date on which the consent is signed;

8) a statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and
9) the date, event or condition upon which the consent will expire if not revoked before. This data, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

PATIENT CONSENT AND AUTHORIZATION FORM FOR DISCLOSURE OF CERTAIN HEALTH INFORMATION

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____ Date of Birth (mm/dd/yyyy):_____

Address: _____ City: _____ State: _____ Zip:_____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize access, use and disclosure of my:

Check all of the boxes to identify the information you authorize to disclose:

☐ Drug or alcohol abuse treatment information
☐ Mental health treatment information

FROM WHOM: Specific person(s) or organization(s) who I am authorizing to release my information under this form: ☐ **All health care providers involved in my care.** ☐ **All programs in which the patient has been enrolled as an alcohol or drug abuse patient, or** ☐ **Any drug or alcohol treatment program or other health care provider, pharmacy or organization providing care coordination that is affiliated with the XYZ HIO** **Only these providers**			
Person/Organization Name:	**Phone:**	**Address:**	**Secure email address:**

TO WHOM: Specific person(s) or organization(s) permitted to receive my information:

- ☐ **To the HIE [Name]**
- ☐ **The HIE and any provider(s) involved in my care in the HIE as of today's date ONLY**
- ☐ **The HIE and only these specific providers**

Organization Name:	Phone:	Address:	Secure email address:	
ONLY THESE INDIVIDUAL PROVIDERS				**Some HIEs cannot manage only individual providers at this point in time**

Amount and Kind of Information: The information to be released may include but not be limited to: Laboratory, Medications, Medical Care & HIV/Aids, Alcohol & Substance Abuse and Mental or Behavioral Health information		

PURPOSE: The information shared will be used: ☐ **To help with my Treatment and Care Coordination** ☐ **To assist the provider or organization to improve the way they conduct work** ☐ **To help Pay for my Treatment**	**Treatment** **Operations** **Payment**	**ONLY USE WHAT IS APPROPRIATE FOR THE HIE. SOME HIEs ONLY PROVIDE EXCHANGE FOR "TREATMENT"**
EFFECTIVE PERIOD: This authorization/consent/permission form will remain in effect until (enter date, **event or condition** upon which this authorization/consent expires):_____ _____. **If there is no date entered the consent will be valid for one year from the date this form is signed.**		**Best practice is to always ask for a date any date. Events are not computable e.g. how to tell when someone dies. HIE would never know**

<u>REVOKING MY PERMISSION</u>: I can revoke my permission at any time by giving written notice to the person or organization named above in the "To Whom" or "From Whom" sections "except to the extent the disclosure agreed to has been acted on.		

In addition:

- **I understand that an electronic copy of this form can be used to authorize the disclosure of the information described above.**
- **I understand that there are some circumstances in which this information may be redisclosed to other persons according to state or federal law.**
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed.**

"This HIE consent does not permit use of my protected health information in any criminal or civil investigation or proceeding against me without an express court order granting the disclosure unless otherwise permitted under state law."

Accept recommended language 5/4/12

X_____ _____

Signature of Patient or Patient's Legal Representative **Date Signed (mm/dd/yyyy)**

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ **Parent of minor**
- ☐ **Guardian**
- ☐ **Other personal representative (explain: _____ _____)**

NOTE: Under some state laws, minors must consent to the release of certain information. The law of the state from which the information is to be released determines whether a minor must consent to the release of the information.

This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Issues/Challenges:

- Some HIEs cannot process only specific providers in the "To Whom" Section
  - Is "All or Nothing"
- Is "All or Nothing" for "Type and Amount" of Data
  - Data Segmentation is not available in all systems today to support Data Segmentation
- HIEs cannot currently process "Only providers in the HIE as of the date of signing the form"
  - Barriers due to technology, cost & operational issues for HIEs and providers

Possible Solutions:

- Use DIRECT only with a Provider Locator Service provided and supported by the HIE
  - Can work in an HIE that is not storing any data and just providing the "pipes" e.g. IL HIE
- Other solutions are in development

Possible Solutions:

- Bring behavioral health data into the HIE but do not "render" it to the provider until the provider has attested with a second sign on that they have a treating relationship with the patient
  - 4 of the 5 HIEs do require this attestation
    - All have audit trail capabilities to track access
- Other solutions are in development

ONC S&I Data Segmentation Workgroup

- Each Data element will be tagged at the EHR level with data describing the actual data to be delivered
  - "Metadata"

- Metadata will include attributes of the data to be shared in relation to consent e.g.
  - Is "Restricted" or "Confidential" in nature
  - Effective Date of consent
  - Termination date of consent
  - If not "all providers" which specific providers are allowed access etc.

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NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration

www.integration.samhsa.gov

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